

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>003283</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/03/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRY CHARM VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7212 US HWY 31 S</b> <b>INDIANAPOLIS, IN 46227</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00181028.</p> <p>Complaint IN00181028 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: September 2 &amp; 3, 2015</p> <p>Facility number: 003283 Provider number: 003283 AIM number: N/A</p> <p>Census bed type: Residential: 58 Total: 58</p> <p>Sample: 4</p> <p>Country Charm Village was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00181028.</p> <p>QR was completed by 14466 on September 08, 2015.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE